STATE OF CALIFORNIA - DEPARTMENT OF FINANCE

PAYEE DATA RECORD

(Required when recieving payment from the State of California in lieu of IRS W-9) STD. 204 (REV 8/2003)

	INSTRUCTIONS: Complete all information on this form. Sign, date, and return to the state agency (department/office) address shown at the						
1	bottom of this page. Prompt return of this fully completed form will prevent delays when processing payments. Information provided on this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information and Privacy Statement. NOTE: Governmental entities, federal, state, and local (including school districts) are not required to submit this form.						
	AYEE'S LEGAL BUSINESS NAME (Type or Print)						
2	I ATEL O SEONE DOUBLE OF HAME (1990 OF FIM)						
1000	SOLE PROPRIETOR - ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)	E-MAIL ADDRESS					
	ILING ADDRESS BUSINESS ADDRESS						
	CITY, STATE,ZIP CODE	CITY, STATE,ZIP CODE					
	FEDERAL EMPLOYERS IDENTIFICATION NUMBER (FEIN):	-			1		
3							
	PARTNERSHIP CORPORATION						
	ESTATE OR TRUST LEGAL (e.g., attorney services)						NOTE: Payment
PAYEE	will not be						
ENTITY	EXEMPT (nonprofit) medical (e.g., dentistry, psychotherapy, chiropractic, etc.) processed without an accompanying						
TYPE	ALL OTHER taxpayer I.D.						
CHECK	number.						
BOX	INDIVIDUAL/SOLE PROPRIETOR						
ONLY	ENTER SOCIAL SECURITY NUMBER:						
	(SSN required by authority of California Revenue and Tax Code Section 18646)						
4	California Resident - Qualified to do business in California or a permanent place of business in California.						
	California nonresident (see reverse side) - Payments to nonresidents for services may be subject to State income tax						
PAYEE	E withholding. NCY NO services performed in California.						
RESIDENCY							
01/1100	Copy of Frandchise Tax Board waiver of State Withholding attached.						
	I hereby certify under penalty of perjury that the information provided on this document is true and correct.						
5	Should my residency status change, I will promptly inform the State agency below.						
	AUTHORIZED PAYER REPRESENTATIVE'S NAME (Type or Print) TITLE						
	AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)						
	SIGNATURE	DATE TELEPHONE NUMBER				IUMBER	
						()	
	Please return completed form to:						
	Department/Office:						
6							
	Unit/Section:						
	Mailing Address:						
	City/State/Zip:						
	Telephone: () Fax: () E-mail Address:						
	- man Address.						

ADA Notice For individuals with sensory disabilities, this document is available in alternate formats. For information call (916) 654-6410 or TDD (916) 654-3880 or write Records and Forms Management, 1120 N Street, MS-89, Sacramento, CA 95814.